Editor—Venous thromboembolism (VTE) is a known cause of death. Approximately 25 000 people die from preventable hospital-acquired VTE every year in the UK and 71% of patients at risk of developing VTE do not receive prophylaxis.¹ National Institute of Clinical Excellence (NICE) guidelines do not recommend routine VTE prophylaxis during ophthalmic surgery under regional anaesthesia.² This advice is perhaps applicable to cataract surgery. Complex and prolonged vitreoretinal (VR) surgery with intravitreal gas injection, requiring special postoperative posture, immobilizes patients and the VTE risk increases commensurately.

We conducted an electronic survey (Google Docs™) of 33 international anaesthetists involved in the management of VR surgery. These anaesthetists had participated as speakers in three consecutive World Congresses of Ophthalmic Anaesthesia from 2004–2014. One anaesthetist from each country was included in the survey. Twenty responses (response rate 60.6%, 16 consultants and 4 specialists) were received and the responding anaesthetists had >11 years experience. Forty-five percent of respondents had seen cases of VTE after VR surgery. Although a majority of respondents felt that the intraoperative use of VTE prophylaxis was important regardless of anaesthesia technique used, preventive measures were not routinely instituted. While 65% of respondents felt that VTE prophylaxis should be used routinely during special postoperative guaranteeing, 30% were of the opinion that it was unnecessary. Respondents were cognizant of simple and other combined methods of preventing VTE such as good hydration, pneumatic compression, anti-embolic stockings, frequent leg exercises (on the operating table in awake patients), mobilizing break every hour and thermoelastic socks, however, they would not utilize these methods for their patients. More than 95% of respondents were concerned in the scenario when systolic blood pressure was higher than 180 mm Hg and diastolic pressure higher than 100 mm Hg; 90% of respondents would be very concerned if platelet count was <50 000, if there was a history of bleeding (haemophilia, von Willebrand disease, Factor VIII deficiency) or recent stroke, and in patients receiving antithrombotic agents. Only 10% were aware of departmental guidelines, while 90% did not know if any local, national or international guidelines existed; 40% stated that there were routine checks for indications or contraindications to anti-embolic stockings in preassessment clinics, while 60% were unaware. Only 25% of respondents routinely assessed for postoperative signs and symptoms of VTE such as calf pain, calf swelling, dyspnea, hypoxemia, chest pain and desaturation. This survey has certain limitations. We would have liked to increase the sample size by including more countries and perhaps more anaesthetists from each participating country but the logistics were prohibitive. The response rate was less than desired because some had retired from active clinical practice, some probably did not receive our request because of change in the email addresses, whilst some might have felt this issue clinically unimportant.

We have identified that anaesthetists are aware of the risk of VTE during prolonged VR surgery and postoperative posturing. Despite the availability of simple preventative measures, prophylaxis is not routinely offered. We also identified that there are no published robust guidelines for VTE prophylaxis, in patients undergoing VR under regional anaesthesia. Results of an earlier survey of 24 members of British and Eire Association of Vitreoretinal Surgeons (BEAVRS),³ which recommended that VTE risk assessment should be undertaken on patient over the age of 60, undergoing a procedure under general anaesthesia and even regional anaesthesia, should the patient be required to lie still for the prolonged surgery. Our survey supports BEAVRS findings. Perhaps a large multicentre study is desirable and future data will help in producing international guidelines.

**Declaration of interest**

None declared.

**References**

2. NICE Clinical Guideline 92. Venous thromboembolism: reducing the risk. Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients

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C. M. Kumar*, J. Macachor and E. Seet

Singapore, Singapore

*Corresponding author. E-mail: chandra.kumar2406@gmail.com

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**References**


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Teaching anaesthetists the skills of communication

A. J. Wardle¹, A. Osman¹, L. Falconer² and B. W. Howes³,*

¹London, UK, ²Liverpool, UK, and ³Bristol, UK

*Corresponding author: E-mail: ben.howes@bristol.ac.uk

Editor—Good communication skills (CS) are key for clinical practice and are associated with improved patient outcomes and satisfaction.¹ ² Anaesthesia is the largest hospital specialty, making it a principle target to leverage improvement. CS training for anaesthetists remains insufficiently studied and poorly understood.³ CS are not part of the training curriculum, and it is unknown how best to approach the teaching in this area. We studied consultant anaesthetists’ views of teaching in CS, focusing on preoperative communication. We aimed to gather views on current practice and future priorities in CS teaching.

An anonymous survey (20-questions) of consultant anaesthetists was distributed throughout several Trusts in the UK. It was developed by consultant anaesthetists in a series of pilots and distributed without incentive via trust email (SurveyMonkey). Ethical approval was deemed ‘not required’ by the local committee.

One hundred and twenty nine responses from 177 invites (73%) were collected, with 128/129 (99%) of responders having been involved in teaching within the past 12 months. Generally, the responders were involved in teaching anaesthetic trainees. Results are outlined in Table 1.

Free text responses suggested introducing distinct CS teaching modules into training (37/129), not assuming CS to be already acquired by trainees (32/129) and increasing recognition of the patient experience (26/129). Suggested topics to improve CS but believe these to be generalizable to the wider doctor-patient relationship. We believe this area of training deserves more attention, and we could start by looking at other specialties such as general practice.

We acknowledge that this work focuses only on preoperative CS but believe these to be generalizable to the wider doctor-patient relationship. We believe this area of training deserves more attention, and we could start by looking at other specialties such as general practice.

<table>
<thead>
<tr>
<th>Question (Have/Do you . . ..?)</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducted a CS teaching session</td>
<td>22/129 (17)</td>
</tr>
<tr>
<td>Been educated regarding CS in past yr</td>
<td>33/129 (26)</td>
</tr>
<tr>
<td>Asked patients regarding the level of detail on induction</td>
<td>64/129 (50)</td>
</tr>
<tr>
<td>Asked patients for communication feedback</td>
<td>36/129 (28)</td>
</tr>
<tr>
<td>Attended a CS based teaching session</td>
<td>93/129 (72)</td>
</tr>
<tr>
<td>Found that your CS improves with CS teaching</td>
<td>75/93 (81)</td>
</tr>
<tr>
<td>Felt that the current system is good at CS teaching</td>
<td>27/129 (21)</td>
</tr>
<tr>
<td>Desire an increase in the quantity of CS teaching</td>
<td>65/129 (50)</td>
</tr>
<tr>
<td>Desire an increased in the quality of CS teaching</td>
<td>108/129 (84)</td>
</tr>
<tr>
<td>Mostly taught yourself CS</td>
<td>85/129 (66)</td>
</tr>
<tr>
<td>Believe an even combination of learned and taught CS is desired</td>
<td>90/129 (70)</td>
</tr>
</tbody>
</table>

Declarations of interest

None declared.

References


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